



STATE OF MAINE BOARD OF PHARMACY

Application and applicant information to assist in completing your application

Mail Order Pharmacy Change of Pharmacist in Charge

READ THIS CAREFULLY

Please do not submit a partially completed application, including failure to submit all required supporting documents, your application will not be accepted and will be returned. You will be required to submit a new application together with the fee, fees are nonrefundable, including applications that are incomplete. Only fully completed applications will be accepted.

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603
TTY/Hearing Impaired 1-888-577-6690
FAX (207) 624-8637

Web address: www.maine.gov/professionallicensing
Email: pharmacy.lic@maine.gov

INFORMATIONAL

- ✓ Please do not call our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.
- ✓ If there is an urgent need to contact us, please be advised that we will only discuss your application with the contact person named in the application to avoid miscommunications. This is done not only for your protection, but to also avoid any complications with too many hands involved, which generally leads to miscommunication or misunderstandings. Our goal is to streamline your process, not complicate it.
- ✓ Once your application for a change of a pharmacist in charge has been approved a new license will be printed and mailed. Please be advised that licenses are printed off site and require at least 14 business days for delivery.
- ✓ Incomplete applications or documents that have been modified or altered in any way, including use of a white out substance will not be accepted and will be returned.
- ✓ Pursuant to 32 MRS § 13752 (2)(C) the pharmacist in charge that is "the" named pharmacist in charge for a mail order pharmacy must be the same pharmacist in charge named for the Mail Order Pharmacy license in the state that the pharmacy is physically located.

LAW AND BOARD RULE REFERENCE

Information contained in this application is not a substitute for carefully reviewing applicable laws and rules. You may obtain a copy of the laws and board rules online at www.maine.gov/professionallicensing—click on 'professions and occupations' then scroll to and click on 'pharmacy' which will bring you to the Board of Pharmacy web page. Please use the topic selection grouping in the blue panel to the right of your screen.

Notwithstanding, please pay particular attention to the following:

- 32 MRSA c. 117, Subchapter 5
- Board Rules, Chapter 11

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 Hearing Impaired: (888) 577-6690 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.



**STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
COMPANY APPLICATION**

APPLICANT INFORMATION (please print)			
NAME OF MAIL ORDER PHARMACY			
FEIN OR SSN			
PHYSICAL LOCATION OF THE MAIL ORDER PHARMACY			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ()		FAX # ()	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION (must be an owner or officer of the entity)			
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.			
SIGNATURE		DATE	

**Board of Pharmacy
Change of Pharmacist in Charge
for a Mail Order Pharmacy
Required Fee: \$100.00 (Non Refundable)**

Maine Mail Order Pharmacy License #

MO _____

Expiration Date _____

Office Use Only:

1457 - \$100.00

Office Use Only:

Check # _____

Amount: _____

Cash # _____

Lic. # _____

Issue Date _____

Exp. Date _____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print name on card)

I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my VISA MASTERCARD the following amount: \$ _____

Card number:

Expiration Date /

SIGNATURE

DATE

SECTION 1: COMPANY INFORMATION

Name of Mail Order Pharmacy	
Mail Order Pharmacy Telephone Number	Mail Order Pharmacy Fax Number
()	()
Toll-Free Telephone Number	E-mail Address
()	
Web Address	DEA # <i>(Required pursuant to Rules, Chapter 11, Section 1 (1)(E), if not applicable, you must provide a written statement)</i>
All Trade Names or Business Names of the Mail Order Pharmacy	

SECTION 2: PHARMACIST IN CHARGE INFORMATION *(32 MRSA §13702-A (23) "Pharmacist in charge means the pharmacist who is responsible for the licensing of the pharmacy," and the contact person for this office for licensing the mail order pharmacy.)*

Last Name	First Name	Middle
Contact Address		
City	State	Zip Code
Telephone Number	E-mail Address	
License Number:	State Issued	License Expiration Date:

EFFECTIVE DATE OF CHANGE

Effective date you, the pharmacist in charge, will take over as PIC

INITIALS OF APPLICANT

SECTION 2 Con't—PHARMACIST IN CHARGE INFORMATION

THIS SECTION MUST BE COMPLETED BY THE PHARMACIST IN CHARGE (“PIC”). Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

CRIMINAL BACKGROUND DISCLOSURE *NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.*

<p>Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has this entity ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked this entities state permit to prescribe or dispense controlled substances? If yes:</p> <ol style="list-style-type: none"> 1. DEA action or Other Entity (Name) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper. 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <ol style="list-style-type: none"> 1. Medicare OR Medicaid Program (State) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper. <p>Clarification on programs:</p> <ul style="list-style-type: none"> • Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease. • Medicaid – Health program administered by the United States government for people with limited incomes. • MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid. 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Have you ever been convicted by any court of any crime? If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? If yes, enclose a detailed explanation and copies of all documents.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

INITIALS OF APPLICANT

SECTION 3: NOTICES

10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

Notice to Consumers (Board Rule Chapter 11, Section 5)

A mail order prescription pharmacy and mail order contact lens supplier shall include with each prescription filled prominent notice that complaints against the mail order prescription pharmacy may be filed with the Complaint Coordinator, Office of Professional and Occupational Regulation, 35 State House Station, Augusta, ME 04333.

INITIALS OF APPLICANT

MAIL ORDER PHARMACY— CHANGE OF PHARMACIST IN CHARGE—Checklist affirmation

Please check mark each box to affirm that you have enclosed the information and documents required for this application. This affirmation checklist does not replace the requirements outlined in the Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information. This checklist is designed as a tool to confirm that your application is complete and ready to forward to our office.

CHECKLIST—please checkmark as an indicator that you have completed the following.

- Each section of the application has been completed.
- Each page of the application, where noted, has been initialed.
- Signature present where noted.
- Check made payable to: Treasurer State of Maine in the amount of \$100.00 is enclosed, or Credit card authorization completed.
- A copy of the consent agreement or order issued by the Board or jurisdiction is enclosed if licensure discipline has been indicated.
- A copy of the Court Judgment and Decision is enclosed if convicted of a crime, including a written statement, in your words, regarding the details of the crime.

SECTION 4: CERTIFICATION AND SIGNATURES

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application and in accompanying documents is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information as truthful and factual. I also acknowledge that an incomplete, altered (including the use of any white out substance), defaced, including use of white out, or compromised application will not be accepted and will be returned and fees forfeited. This includes, but not limited to, unanswered questions, lack of appropriate signature, illegible, missing supporting documents, and/ or missing or wrong fee.

Printed Name of Mail Order Pharmacy Owner or Officer	Title
Signature of Mail Order Pharmacy Owner or Officer	Date

Also, as the Pharmacist in Charge certify by my signature that I have read and understand the Maine Board of Pharmacy laws and rules and related laws and rules as it applies to a Mail Order Pharmacy. I also certify that the management of the pharmacy will be vested with the pharmacist in charge in all matters directly or indirectly related to the practice of pharmacy or in any matters related to health, welfare, and safety of the public, as required by laws and rules.

Printed Name of PIC	Title
Signature of PIC	Date